



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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February 1, 2010

Tom Whittemore, Administrator
Communicare #7 (Cougar)
40 West Franklin Road, Suite F
Meridian, Idaho 83642

RE: Communicare (Cougar), Provider # 13G072

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey of Communicare #7 (Cougar), which was concluded on January 21, 2010.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

TomWhittemore, Administrator
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4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction.

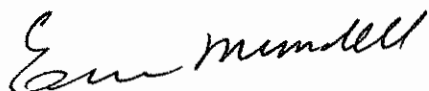
For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 14, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,



ERIC MUNDELL
Health Facility Surveyor
Facility Fire Safety and Construction Program

EM/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2010
NAME OF PROVIDER OR SUPPLIER COMMUNICARE INC., #7 (COUGAR ST)			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVE NAMPA, ID 83686		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a one story, Type V(000) structure. Residents sleep on the first story (i.e., ground level). The facility is fully sprinklered and is licensed for 8 beds. The facility was surveyed in accordance with applicable fire/life safety requirements set forth in the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability and under 42 CFR 483.470. No federal deficiencies were cited during the annual fire/life safety survey: The surveyor conducting the survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program		K 000		

RECEIVED
FEB 16 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator 2-12-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010
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M 000	16.03.11 Initial Comments	M 000	<p style="text-align: center; font-size: 2em; font-weight: bold;">RECEIVED</p> <p style="text-align: center; font-weight: bold;">FEB 16 2010</p> <p style="text-align: center; font-weight: bold;">FACILITY STANDARDS</p>	3/31/10
	<p>The facility is a one story, Type V(000) structure. Residents sleep on the first story (i.e., ground level). The facility is fully sprinklered and is licensed for 8 beds. The facility was surveyed in accordance with applicable fire/life safety requirements set forth in the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability and 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF-MR).</p> <p>The following deficiency was cited during the annual fire/life safety survey:</p> <p>The surveyor conducting the survey was:</p> <p>Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program</p>			
MM327	16.03.11.110.02(h) Emergency Electrical Service	MM327	<p>MM327</p> <p>We have received clarification as the specifications for lighting the panel as we had not previously been aware that the control panel needed automatic lighting and will locate and install a light as required.</p> <p>The new panel light will be tested on a monthly and annual basis in keeping with the directions we have received and the results noted on the Monthly Preventative Maintenance Check list by the home AQ.</p>	
	<p>Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system. This Rule is not met as evidenced by:</p> <p>Based on observation it was determined that the facility had not ensured emergency lighting was available for one of one fire control panels. The census was eight. The findings include:</p> <p>Observation on January 20, 2010 at 12:45 p.m. disclosed that emergency lighting was not installed to illuminate the fire control panel. There was no residual light from other emergency lighting to provide any illumination. Lack of emergency illumination on the fire control</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2-12-10
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Bureau of Facility Standards

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MM327	Continued From Page 1 panel would potentially cause inability of staff to operate the panel during power failure.	MM327		